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ABSTRACT

The effects of alcohol and other drug abuse are recognized as a serious problem in U.S. communities. Policy efforts and increased law enforcement have only a minimal impact if prevention strategies are not consistent with the community's level of readiness, are not culturally relevant, and are not community-specific. A model has been developed for accurately assessing a community's level of readiness to initiate prevention strategies. The model has nine stages of readiness--tolerance, denial, vague awareness, preplanning, preparation, initiation, institutionalization, confirmation/expansion, and professionalization. The most appropriate method for assessing the community's level of readiness is to survey key community members who know about the type of problem examined. The model can be used by community members to develop interventions appropriate to each stage of their community's readiness, thus increasing the potential for strategies to be successful and cost-effective. Overall support from the community, known as community climate, will in large part determine the success of prevention efforts. If prevention efforts are in place, they should not be reduced because of a lack of overall community involvement; rather, interventions should be undertaken to alter the community climate. The community readiness model can be adapted to other issues such as health and nutrition, environmental, social, and personal problems. (Contains 14 references.) (TD)

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Using the Community Readiness Model in Native Communities

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Abstract

The effects of alcohol and other drug abuse are recognized as a dangerous threat to communities in the United States. Policy efforts and increased law enforcement may have only a minimal impact if the prevention strategies are not consistent with the communities' level of readiness, are not culturally relevant, and are not community-specific. This article presents a model for accurately assessing a community's level of readiness to initiate prevention strategies. It introduces the concept of "community climate" and its impact on community readiness. The model can be used by community members to develop interventions appropriate to each stage of their communities' readiness, thus increasing the potential for strategies to be successful and improving the cost-effectiveness of prevention programs.

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Alcohol and other drug abuse remains a serious problem in the United States, and after a decade of decline among adolescents it is once again on the rise (Johnston, O'Malley, and Bachman, 1995). The most recent published information (Beauvais, 1996) indicates that the same patterns of abuse found among U.S. adolescents also occur among American Indian youth. These increases are occurring despite increasingly stringent national policies and the implementation of a vast array of drug and alcohol prevention programs. It is quite possible that health-oriented prevention initiatives are not as effective as they could be, since they often ignore the critical element of community readiness and its willingness to address the problems of substance abuse. Unless they are tailored to the level of a community's ability to respond to a problem, interventions will fall short of their intended goals. This chapter will describe a process for assessing and facilitating community functioning and readiness to address drug prevention.

Drug abuse prevention in American Indian and Alaska Native communities is complicated by socioeconomic conditions that present many challenges and obstacles to those communities attaining a satisfactory quality of life. Although recent years have brought some political successes, there have been few economic successes. Many Native families still experience poor nutrition, live in substandard housing, and lack the resources necessary to provide their children with choices for positive opportunities—all factors that are believed to place them at high risk for substance abuse. Many assert that when Native people live in rural communities or reservation areas, substance abuse problems may be even more pervasive because there are few effective local resources for either treatment or prevention.

When one considers the many tribal and village differences, it is not surprising that alcohol and drug use among Natives varies from one community to the next (May, 1982). May (1986) cites some tribes as having fewer drinking adults (30 percent) than the U.S. population (67 percent) while other tribal groups have more (69 percent–80 percent). Despite this variability, when American Indian populations are examined as a whole the

statistics regarding alcohol consequences are quite alarming. (See Moran in this volume for a summary of alcohol-related morbidity and mortality.) These statistics translate into communities with overwhelming challenges and too few reliable resources to address their problems. In response, too often people from outside the community come in and attempt to identify the problems and prescribe solutions. Few, however, are successful because outsiders seldom understand the dynamics and cultural nature of the community and once the person leaves, their "prescriptions" falls by the wayside.

The answer to successful prevention may lie in locally developed and implemented prevention programs. Though anecdotal evidence suggests that some prevention programs have met with success, few have been rigorously documented to ascertain the degree of their effectiveness. Because so many different sectors of a community are affected by substance use, prevention efforts are often fragmented. In truth, underemployment, poverty, prejudice, and the lack of opportunity typically mark all communities, neighborhoods, villages, and reservations that are identified with high alcohol and other drug involvement. It is therefore difficult for many communities to implement effective drug and alcohol prevention programs that are culturally specific and community relevant, when there are so many other day-to-day survival issues these communities must face. Many prevention-oriented programs have been launched in the past few decades, ranging from educational awareness to more aggressive experiential activities, but many have met with failure. The communities often had so many pressing problems to confront that they just were not ready to initiate prevention programs.

Other factors must be considered as well. For instance, smaller communities and reservation areas often have to contend with political and social factors that impact success or failure of a new program. When key people in a community are affected by alcoholism, either personally or within their families, it is often difficult to gain their collaboration and support for an alcohol-use prevention project. Without acceptance and

support for prevention endeavors from all key elements of a community, success is unlikely.

The primary purpose of this chapter is to introduce a method for assessing the level of readiness of a community to develop and implement a drug and alcohol prevention program. Steps will be discussed that will allow a community to assess readiness for program implementation and determine the climate of the community relative to the specific problem issue. Potential interventions for each stage of community readiness will be presented as well. Because under this method community members must identify their own community problems, concerns, strengths and resources, and develop their own specific strategies for intervention, the method greatly increases the potential for cultural relevance and community-specific application.

Development of the Community Readiness Concept

The initial concept of a community's "readiness" for prevention efforts evolved simultaneously from two areas of research conducted by the Tri-Ethnic Center for Prevention Research at Colorado State University: (1) consultation and training of field professionals from Mexican-American and American Indian communities by the Center's facility; and (2) a project to develop and test media programs aimed at preventing drug and alcohol abuse in small communities.

The purpose of the first project was to provide technical assistance in the development of effective prevention programming to underserved populations. The Center's "Community Team" visited sites across the United States, serving as a resource to provide information and transfer knowledge about drug and alcohol prevention. The intent was to bridge the gap between research and service provision. As the team visited numerous sites, it noted the emergence of similar themes as communities identified their concerns. The team also found that

communities experienced varying degrees of difficulty in building effective networks and coalitions and further, that underserved communities often lacked the resources to direct them in proceeding with effective prevention strategy development. As a result, the team developed a workshop and practical manual that would provide communities with the tools and instruments to assess their community strengths, resources, needs, and barriers for use in development of effective and culturally specific prevention strategies.

Initially, when the Community Team was invited into a community, it would request the community gather together the key people in it to attend the workshop. Participants then worked closely with the Community Team to identify the concerns in their area. Using these findings, the participants would devise workable and practical strategies that were both culturally appropriate and practical for that community. The community found it easier to invest in the effort because the plan was specific to their needs and consistent with their culture. Because the Community Team members had clinical backgrounds as well as research experience, it seemed only logical to apply the concept of an individual diagnostic assessment to the community as a whole. Just as an individual experiences differing stages of readiness for an intervention, so does a community.

At the same time, a second project within the Center was pilot testing a workshop to train members of ethnic communities in the various aspects of drug prevention. Small teams from ethnic communities were invited to the Center to participate in comprehensive prevention training (including needs assessment techniques, information on prevention programs, and grant writing), then sent back to their communities to initiate or improve local prevention efforts. The pilot study, however, did not yield the desired effects. Although the trainees learned a lot about prevention programming, when they returned home they had little impact in their communities. Follow-up interviews suggested that their communities did not understand the problem and were not ready to invest in prevention programming.

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Although the training did not lead to significant changes in their communities, a major lesson was learned from this pilot project: when initiating or improving prevention programs, it is first necessary to prepare a community for change. Training staff in how to implement a prevention program is only appropriate when the community is ready to either initiate a program or expand an existing program.

From these experiences came the seeds of the Community Readiness Model. The two projects, relatively independent of one another, indicated the need for much more information about communities, including a method for assessing community "readiness," and then the need for development of a plan or process for moving communities to the actual planning and program implementation stages. The first steps were to create a theoretical model of community readiness and then to develop and validate methods for accurately measuring community readiness.

Theoretical Framework for Community Readiness

Researchers and practitioners alike have found that communities vary greatly in their interest and willingness to try new prevention strategies (Weisheit, 1984; Aniskiewicz and Wysong, 1990; Bukoski and Amsel, 1994). While some communities may reject public recognition of a local problem, other communities show considerable interest in an identified problem, but have little knowledge about what to do about it. Still other communities may have highly developed and sophisticated prevention programs. Before the Center's work, no standard method for describing community readiness or specific methods for assessing community readiness existed. The closest approach in the literature was community development theory, but that theory did not directly address community readiness, particularly at the earliest stages.

The Community Readiness Model was developed using two research traditions: psychological readiness for treatment and community development. Psychological readiness may be defined as an individual's sense of dissatisfaction resulting from perceived discrepancy between what is and what should be, with the subsequent motivation to seek information, to learn, and to adopt new behaviors aimed at alleviating this discrepancy. Prochaska, DiClemente, and Norcross (1992) provide the best example. They present a five-stage model for psychological readiness: (1) the *precontemplation* stage (involves minimal awareness of a problem and consequently no intent to invest in change); (2) the *contemplation* stage (includes awareness but no commitment to action), (3) the *preparation* stage (involves clear recognition of the problem and exploration of options); (4) the *action* stage (involves implementation of proposed behavioral changes); and (5) the *final maintenance* stage (includes both consolidation of behavioral changes and preventing relapses).

The field of community development provides two approaches that are partially relevant: the innovations decision-making process (Rogers, 1983) and the social action process (Warren, 1978). Garkovich (1989) has noted that both of these models recognize the complex dynamic interactions involved in a community-level, consensus-seeking, collective action. Rogers' stages for the innovation's decision-making process include knowledge (first awareness of an innovation), persuasion (changing attitudes), decision (adopting the idea), implementation (trying it out), and confirmation (where the idea is either used again or discontinued after initial trial). Warren's social action approach parallels these stages and focuses on group processes. The stages include stimulation of interest (recognition of need), initiation (development of problem definition and alternative solutions among community members who first propose new programs), legitimization (where local leaders accept the need for action), decision to act (developing specific plans which involve a wider set of community members), and action (or implementation).

The Community Readiness Scale

These concepts, and the Center's experiences, provided an initial framework from which to create a model as well as to develop a method for actually assessing community readiness. Using a series of interactive steps based on expert raters and the Delphi method, followed by several revisions, a nine-stage model of community readiness was eventually devised. The model begins with a stage of *community tolerance* that suggests that the behavior of interest (e.g., youth drug abuse) is normative and accepted. A *denial* stage involves the belief that the problem does not exist or that change is impossible. A *vague awareness* stage involves recognition of the problem, but no motivation for action to change it. The *preplanning* stage indicates recognition of a problem and agreement that something needs to be done. The *preparation* stage involves active planning. The *initiation* stage involves implementation of a program. The *institutionalization* stage indicates that one or two programs are operating and are stable. The *confirmation/expansion* stage involves recognition of program limitations and attempts to improve existing programs. Finally, the *professionalization* stage is marked by sophistication, training, and effective evaluation (see Table 5.1 for expanded descriptions).

Table 5.1. Stages in community readiness

Stage	Description
1. Community tolerance	The behavior, when occurring in a particular social context, is tolerated by community leadership; "It's just the way things are" is a prevailing sentiment. (In this instance, the "leadership" can include anyone in the community who is appointed to a leadership position or is influential in community affairs, e.g., an individual, a parent, a child, a teacher, a clergy person.) Community climate may encourage the behavior; the behavior may be expected of one group and not another (e.g., tolerance varies according to gender, race, social class, age).

2. Denial	There is usually some recognition by community leadership that the behavior itself is or can be a problem, but there is little or no recognition that this might be a local problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be done about it locally. "It's not our problem." "We can't do anything about it." Community climate tends to match the attitudes of leaders and may be passive, guarded, or apathetic.
3. Vague awareness	There is a general feeling among community leaders that there is a local problem and that something ought to be done about it, but there is no immediate motivation to do anything. There may be stories or anecdotes about the problem, but ideas about why the problem occurs and who has the problem tend to be stereotypical, vague, or both. No identifiable leadership exists, or leadership lacks the energy or motivation for dealing with this problem. Community climate does not serve to motivate leaders.
4. Preplanning	There is clear recognition on the part of at least some community leaders that there is a local problem and that something should be done about it. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is discussion but no real planning of actions to address the problem. Community climate may or may not support leadership efforts to deal with the problem.
5. Preparation	Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention activities, actions, or policies, but it may not be based on formally collected data. Leadership is active and energetic. There are decisions made about what will be done and who will do it. Resources (people, money, time, space, etc.) are actively sought or have been committed. Community climate may or may not support these efforts.
6. Initiation	Enough information is available to justify prevention activities, actions, or policies. An activity or action has been started and is under way, but it is still viewed as a new effort. Staff is in

	training or has just finished training. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Community climate may or may not support these efforts.
7. Institutionalization	One or two programs or activities are running, supported by administrators or community decision-makers. Programs, activities, or policies are viewed as permanent. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness nor is there a sense that any recognized limitations suggest a need for change. There may or may not be some form of routine tracking of prevalence. There may be some criticism, but community climate generally supports what is occurring.
8. Confirmation/ expansion	There are standard programs, activities, and policies in place, and authorities or community decision-makers support expanding or improving programs. Original efforts have been evaluated and modified, and new efforts are being planned or tried in order to reach more people, those who are more at risk, or those of different demographic groups. Resources for new efforts are being sought or committed. Data are regularly obtained on the extent of local problems, and efforts are made to assess risk factors and causes of the problem. The community climate may challenge specific programs, but it is fundamentally supportive.
9. Professionalization	Detailed and sophisticated knowledge of prevalence, risk factors, and causes of the problem exists. Some efforts may be aimed at general populations, while others are targeted at specific risk factors, high-risk groups, or both. Highly trained staff are running programs or activities, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs, policies, or activities. The community climate should challenge specific programs, but it is fundamentally supportive.

Each stage of community readiness is a qualitative description based on information about a specific dimension. To determine the appropriate stage of community readiness for prevention, questions were centered on six dimensions that were identified using an anchor rating technique (Smith & Kendall, 1983). Anchor rating uses experts who develop statements that describe stages in a process (see detailed description of development of anchored statements in Oetting et al., 1995).

The original five dimensions found to be pertinent to assessing community readiness were (1) prevention programming, (2) knowledge about prevention programs, (3) leadership and community involvement, (4) knowledge about the problem, and (5) funding for prevention. These dimensions have since been relabeled to (1) existing prevention efforts, (2) community knowledge of programming, (3) leadership, (4) knowledge about the problem and (5) resources for prevention. The reasons for the relabeling are varied. The first four dimensions were relabeled in an effort to better define and clarify the dimension. The fifth dimension was relabeled because the Community Team of the Tri-Ethnic Center has observed in its workshops and follow ups with communities, that in order to sustain prevention efforts and integrate them into the community, it is more effective to rely on local resources (people, money, time, and space) than to become dependent on outside funding. Outside sources of support will usually be time-limited and reliance on them too often results in the effort disappearing altogether when that external funding (e.g., grants) ends. Experience in implementing the model also suggested the need for renaming the initial five dimensions and adding another dimension—community climate. (The titles, questions, and anchors for each of the six dimensions are presented in Tables 5.3 through 5.8.)

Community Climate

Community climate is a critical dimension to be considered when assessing a community's readiness for prevention. Even when there are efforts by individuals and organizations interested in or actually implementing efforts in prevention, the overall community climate may remain either highly tolerant of the problem or relatively passive and watchful during the initiation of a prevention effort. This circumstance greatly impedes prevention work.

After the publication of the Oetting et al. (1995) paper on Community Readiness, further work showed that, while community climate was a determinant of readiness at the tolerance and denial stages, at higher stages, up until the *institutionalization* stage, the overall community climate could be independent of readiness to implement prevention efforts. For example, it was possible to have a relatively high level of readiness on the part of key community leaders who were planning and even coordinating prevention efforts, while having very low levels of support by members of the community at large. It is nonetheless important to consider community climate and initiate efforts to engage the community, which improves the potential for successful intervention. Though community climate had been incorporated into the other measures in previous studies, this dimension has since emerged as a very important and singular factor integral to the assessment of community readiness. Assessment of the stages was found to be highly dependent on community climate. Adding this dimension provided for a more comprehensive and accurate picture of the community and its willingness to accept and implement prevention strategies.

For example, a low level of community readiness, exhibited by *tolerance or denial*, indicates an environment where few effective programs exist. This is consistent with the community climate that indicates that the community would be very unlikely to accept or utilize any new intervention that would be introduced anyway. Under these circumstances, the interventions must accommodate both the readiness and the cli-

mate of the community in order to gain involvement and support. If, on the other hand, the level of readiness is high among leaders but low in the community at large, while there could be established programs, activities, or policies, the community would only tolerate this activity and would lend but little involvement. This is important and suggests that the community climate needs to be improved for prevention efforts to effectively reach and involve the community and successfully impact the problem. However, if prevention efforts are in place and operating, they should not be reduced because of a lack of overall community involvement; rather, interventions appropriate to alter the community climate should be included. It is important to note that poor community climate can prevent movement to a higher stage of readiness. For example, in rural towns there may be drug prevention programs operating in the schools, but there may not be an alcohol prevention program because alcohol use is highly tolerated by the community. In rural towns in tobacco-raising country, there may be drug prevention programs, but no tobacco cessation or prevention programs. Effective prevention must change community norms—an action that must have community involvement. Assessment of community climate is essential in developing strategies for effective prevention.

Assessing Community Readiness

In a community, drug and alcohol abuse consequences can include birth defects; violence directed at intimate partners; child abuse and neglect; increased diabetes, cardiovascular diseases, carcinomas, and liver diseases; property damage; injuries and fatalities involving drug- or alcohol-impaired persons; criminal activity; lost productivity and on-the-job problems; and higher emotional distress from living with someone who is addicted. With so many systems in a community being affected by such a variety of consequences, it is highly unlikely that any one organization or person will have the complete picture. Therefore, a true depiction of the community is not possible

without some framework into which the components can be brought together to put the picture into perspective. The most appropriate method found for assessing the community's level of readiness is a survey of key informants, since the planning, funding, and implementation of prevention programs often lies in the hands of community leaders, and because those people are the ones most likely to know what is happening in their community. This assumption is supported by information gained from participants in the workshops conducted by the Community Team. The key informant survey obtains factual information from community leaders or professionals who would logically be able to provide the data necessary to assess community readiness. The key informants should be selected from among community members who would know about the type of problem examined and about that problem's existing prevention programs. They would be in touch with various segments of community leadership, and would themselves be leaders or professionals working in the community on a day-to-day basis. Usually three to five interviews are sufficient to gather the needed information. If inconsistencies are found in the interview data, more interviews should be conducted until a consensus is obtained. It is suggested that those selected for key informant interviews include representatives of the following groups: school drug and alcohol counselors, community agency representatives, law enforcement representatives, community government officials, tribal representatives, older youth, and/or a media representative.

Key informants are surveyed through semistructured interview questions (see Table 5.2). Interviewers should be skilled, and, prior to beginning the interviews, should develop an in-depth understanding of the stages of community readiness for prevention, of the dimensions, and of how the anchor statements relate to the stages. Interviewers should have sufficient practice in making reliable ratings for the six dimensions. Interviews can be conducted in person or by telephone. The questions related to the six dimensions serve as a format, and the interviewer begins by asking these questions. It may not be necessary to ask every question, or the interviewer may add related questions to get

Table 5.2. Key informant interview questions

These are the questions to be asked to assist in measuring for each of the following six dimensions:

A. Existing Prevention Efforts (programs, activities, policies, etc.)
B. Community Knowledge about Prevention
C. Leadership (includes appointed leaders and influential community members)
D. Community Climate
E. Knowledge about the Problem
F. Resources for Prevention Efforts (people, money, time, space, etc.)

The letters in parentheses indicate the dimension(s) to which the question is generally related.

A and B. Prevention Programming and Community Knowledge about Prevention

1. Does the community see (the issue) as a problem? (B and E)
2. Are there efforts addressing (the issue) in your community? (A)
3. Are the people in the community aware of these efforts? (B)
4. How long have these efforts been going on in your community? (A)
5. What are the strengths and weaknesses of these efforts? (A)
6. How are these efforts viewed by the community? (B)
7. How much do the leaders, groups, or committees in your community know about these efforts? (B)
8. Are there segments of the community in which these efforts do not apply? (A)

   Prompt: segments, for example, include age, religion, ethnicity, gender, or socioeconomic status.
9. Is there a need to expand these services? If no, why not? (A)
10. Are there plans to expand or develop other efforts? If yes, what are the plans? (A)
11. What types of policies and practices (rules and regulations) related to (the issue) are in place in your community? (A)

    Prompt: formal practices include police arresting the offender.
12. Are the people in your community aware of these policies? (B)
13. Are there informal practices, policies, or rules that are in place in your community? (A)

    Prompt: informal practices include police possibly not responding in certain areas.

Table 5.2. (Continued)

14. How long have these policies been operating in your community? (A)
15. Are there segments of the community to which these policies do not apply? (A)

    Prompt: segments, for example, include age, religion, ethnicity, gender, or socioeconomic status.
16. Is there a need to expand these policies? If no, why not? (A)
17. Are there plans to expand the policies? If yes, what are the plans? (A)
18. How are these policies viewed by the community? (B)

C. Leadership ("Leadership" can include anyone in the community who is appointed to a leadership position or is influential in community affairs, i.e., an individual, a parent, a child, a teacher, a clergy person, etc.)

19. Who, in your opinion, are the leaders, formal or informal, in your community? (C)

    Prompt: people whose opinions are respected or who are influential, and who may be contacted informally when issues arise.
20. If informal, how did they become the "leaders"? (C)
21. Does the leadership see (the issue) as a problem? (C)
22. Are the "leaders" in your community involved in prevention efforts? Please list. (C)
23. Would the leadership support prevention efforts? (C)

D. Community Climate

24. What is the general attitude about (the issue) in your community? (D)
25. Is there ever a time when, or circumstance in which, members of your community might think this (issue) is tolerated? (D)

    Prompt: circumstances, for example, include age, religion, ethnicity, gender, or socioeconomic status.
26. Would the community support prevention efforts? If yes, how? (D)
27. What are the primary obstacles to prevention efforts in your community? (D)

    Prompt: obstacles can be people, groups, organizations, attitudes, or resources.
28. Is there a sense of apathy or hopelessness among community members regarding (the issue)? (D)

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Table 5.2. (Continued)

E. Knowledge About the Problem

29. Is there any information about how often (the issue) occurs in your community? If yes, from whom? (E)
30. How do people obtain information in your community? (E)
31. What types of data are available on (the issue)? (E)

F. Resources for Prevention Efforts

32. Who would a victim of (the issue) turn to first? (F)
33. Who provides resources for these efforts and how long will they last? (F)
34. What is the community's attitude about supporting prevention efforts with people, money, time, or space? (F)
35. Do people in your community know what it takes to run these programs or activities? (F)
36. Are you aware of any proposals or action plans that have been written to address (the issue's) prevention? (F)
37. What is the level of expertise and training among those working toward prevention of (the issue)? (F)

Additional Questions To Be Asked If Programs or Policies Are in Place

38. Are you aware if there are any efforts being made to evaluate the prevention efforts or policies that are in place? (A and B)
39. Are the evaluation results being used to make changes in programs, activities, or policies, or to start new ones? (A and B)

The following questions are optional, if you choose to track personal data on the respondents.

What is your age range: (list groupings)

- 19–24
- 25–34
- 35–44
- 45–54
- 55–64

What is your ethnicity?

Your position?

How long have you lived in the community?

May I have your mailing address?

That's all of the questions. Do you have other comments to add or questions you'd like to ask?

Thank you so much for your time.

more specific about an issue. Some minor modifications may be needed to the questions in order to align them to the issue under analysis; more extensive modification may be needed for the policy-related questions. Some issues may lack written formal or informal policy, making this section less applicable to the issue of focus. The interviewer takes detailed notes on each response. When the interviewer believes the questions have all been answered as best as possible, the result should be a qualitative description of what is actually occurring in that community. Immediately after each interview, the interviewer or rater should write a brief statement summarizing the information related to each specific dimension. He or she then gives a numerical rating (1–10) for each of the six anchored scales (see Tables 5.3 through 5.8 for the anchored rating scales) for using the graphic continuum for each dimension. It is often helpful to have two or more interviewers who can later discuss the information and gain a general consensus of the interview information. After the anchored ratings and statements have been completed, the interviewer then turns to the descriptions of the stages of community readiness and assigns a stage ranking to the community. That assignment should not be made simply on the basis of average numerical ratings on the dimensions, but rather should be an qualitative expert judgment based on all of the interview information and the scores on the anchored rating scales. The stage of readiness, with the descriptive material, provides an adequate description of the community's level of readiness for prevention.

It should be pointed out that the interviewers need to be patient since the length of each interview is approximately 25 to 30 minutes. Often many callbacks are required to simply reach the key informants when they have enough time to talk. The average length of time to complete two key informant interviews in a single, small community in one study was approximately 5 weeks, from initial contact to completion of the actual interview. Those with experience or knowledge of substance abuse conduct interviews most effectively. Many respondents use terminology common among treatment and prevention providers, and interviewers familiar with those nomenclatures communicated more easily and effectively.

Table 5.3. Dimension A: Existing prevention efforts (programs, activities, policies, etc.)

Descriptive Statement:

1. Prevention is not important.
2. No plans for prevention are likely in the near future.
3. There aren't any immediate plans, but we will probably do something sometime.
4. There have been community meetings or staff meetings, but no final decisions have been made about what we might do.
5. One or more programs or activities are being planned or changes in policies are being considered and, where needed, staff are being selected and trained.
6. One or more prevention programs, activities, or policies are being tried out now.
7. One or two efforts have been running for several years and are fully expected to run indefinitely; no specific planning for anything else.
8. Several different programs, activities, and policies are in place, covering different age groups and reaching a wide range of people. New programs or efforts are being developed based on evaluation data.
9. Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

Practical Application of the Community Readiness Model

Many respondents have reported that the assessment process itself has proven to be an effective intervention in their communities. They have indicated that answering the questions has made them think about pertinent issues and generated discussion with peers about what should be happening in their community. Even this very basic interaction has resulted in com-

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Table 5.4. Dimension B: Community knowledge about prevention

Descriptive Statement:

1. Community has no concept about what prevention is.
2. Community has no knowledge about prevention programs, activities, or policies.
3. Heard about community prevention efforts, but no real information about what is done or how it is done.
4. Some leaders, groups, or committees in the community are beginning to seek information about existing prevention programs, activities, or policies.
5. Some leaders, groups, or committees have general knowledge about programs or activities and whom they would affect. (Who would do what and for whom.)
6. A group or groups have general knowledge about local efforts and may be complacent about local efforts regardless of their effectiveness and without supporting data.
7. There is evidence that a group or groups have specific knowledge of local efforts including contact persons, training of staff, clients involved, etc., but there is a minimally perceived need for expansion.
8. There is considerable community knowledge about a variety of different community prevention efforts, as well as supporting data related to the level of program effectiveness.
9. Community has accurate knowledge based on thorough evaluation data about how well the different local efforts are working, and on their benefits and limitations.

munity change and strategy development. However, the Community Readiness Model was developed to be used as a tool to help communities more systematically assess their local situation so that they could then identify effective strategies to propel their prevention initiatives. The interventions suggested below are by no means comprehensive nor have they been rigorously tested. They have been, however, utilized effectively by communities at their respective stages of readiness. The strate-

Table 5.5. Dimension C: Leadership
(includes appointed leaders and influential community members)

Descriptive Statement:

1. Leadership resistant to prevention efforts.
2. Leadership passive, apathetic, or guarded.
3. People have talked about doing something, but so far there isn't anyone who has really "taken charge." There may be a few concerned people, but they are not influential.
4. There are identifiable leaders who are trying to get something started, and a meeting or two may have been held to discuss problems.
5. Leaders and others have been identified; a committee or committees have been formed and are meeting regularly to consider alternatives and make plans.
6. Leaders are involved in programs or activities and may be enthusiastic because they are not yet aware of limitations or problems.
7. Authorities and political leaders are solid supporters of continuing basic efforts.
8. Leaders support multiple efforts. Authorities, program staff, and community groups are all supportive of extending efforts.
9. Authorities support multiple efforts, staff is highly trained, community leaders and volunteers are involved, and an independent evaluation team is functioning.

gies associated with the first four stages (*tolerance* through *preplanning*) are generally aimed at raising awareness that a problem may exist and working more individually or in small groups to facilitate change. Home visits to discuss the issues, small sewing groups, discussion circles, and one-on-one phone calls have been used effectively by some communities that self-assessed at this stage. At the *denial* stage, the focus is on creating awareness that the problem exists in this community. At this stage, personalized case reports and critical incidents are likely to have more impact than presenting general statistics or data. Media reports, presentations to community groups, and

Table 5.6. Dimension D: Community climate

Descriptive Statement:

1. The community does not see this behavior as a problem. It is an accepted part of community life: "it's just the way things are."
2. There is little or no recognition that this is a community problem; the prevailing attitudes are "there's nothing we can do" or "only 'those' people do that."
3. Community climate may not support, but would not block, prevention efforts.
4. Leadership may be functioning independently of the community climate during *preplanning*, *preparation*, or *initiation* stages of programs, activities, or policies. The community in general may or may not be involved in these efforts.
5. The majority of the community generally accepts programs, activities, or policies. Support may be somewhat passive.
6. Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for prevention. Participation level is high.
7. All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

similar educational interventions can focus on the general problem in similar communities, but these aids must bring the incidents home to the specific community, to create awareness that there is also a local problem. At the *vague awareness* stage, communities could utilize small group events, potlucks or potlatches, and newspaper editorials or articles. Although use of national or regional data may be meaningless to community residents, local survey data (i.e., school or phone surveys) may be of value. It should be noted that at this stage of readiness, school officials and parents may still be somewhat resistant to initiating these types of prevention activities; however, they should still be encouraged to do so for the growth of the community. During the *preplanning* stage, communities start gath-

Table 5.7. Dimension E: Knowledge about the problem

Descriptive Statement:

1. Not viewed as a problem.
2. No knowledge about the problem.
3. Some people here may have this problem, but no immediate motivation to do anything about it.
4. There is clear recognition that there is a local problem, but detailed information is lacking or depends on stereotypes.
5. General information on local problem is available, but is not based on formally collected data.
6. Leaders have enough information about the problem to justify doing something.
7. Detailed information about local prevalence may be available and people know where to get specific information.
8. There is considerable specific knowledge about prevalence and causes, risk factors, and consequences.
9. Specific information about the problem is being used to target high-risk groups and plan the types of prevention programs needed. Information about the effectiveness of local programs is available.

ering information on effective prevention programming, examining pre-existing curricula and educational materials that are culturally relevant, making efforts to involve key people in the community in the planning process, conducting local focus groups or small public forums to discuss the issues, and increasing media exposure.

The stages of *preparation* and *initiation* are generally aimed at gathering and providing community-specific information to the general public. For instance, at the *preparation* stage, it is suggested that a valid and reliable school drug and alcohol survey be initiated in an effort to obtain accurate local data. Community telephone surveys could be initiated to gain information about community attitudes and beliefs related to drug

Table 5.8. Dimension F: Resources for prevention (people, money, time, space, etc.)

Descriptive Statement:

1. There is no need for resources to deal with this problem.
2. There is the belief that there are no resources available for prevention or that barriers seem insurmountable.
3. It might be possible to initiate prevention efforts, but there is uncertainty about how much it would take and about where the resources would come from.
4. A committee or person is finding out what might be needed for a prevention effort and is considering how the resources might be found.
5. It is known what is needed to staff and run a program or activity. A proposal has been prepared, submitted, and may have been approved. The people who will be involved have agreed to participate.
6. Resources are available, but they are only from grant funds, outside funds, or a specific one-time donation, or the resources are volunteers who are running a program or activity, which is temporary.
7. A considerable part of the support of ongoing efforts is from local sources that are expected to provide indefinite and continuous support.
8. More than one program, activity, or prevention policy is in place and is expected to be permanent, and there is some additional support for further prevention efforts.
9. There is continuous and secure support for basic programs and activities, evaluations are routinely expected and completed, and there are substantial resources for trying new efforts.

and alcohol use. More in-depth local statistics should be gathered, more diverse focus groups should be held to gain a wider representation of the community and develop practical strategies for prevention efforts, and grant development could start. At the *initiation* stage, interventions might consist of conducting training for professionals and paraprofessionals, conducting consumer interviews to gain information about improving services, identifying service gaps, and identifying potential

funding sources that match community needs through accessing computers.

The final three stages—*institutionalization, confirmation/expansion,* and *professionalization*—are more programmatic in nature and aim toward evaluation of efforts and making program modifications based on those evaluations. During the *institutionalization* stage, basic evaluation techniques are initiated in an effort to modify and improve services. In addition, in-service training is provided to increase the number and quality of trained community professionals, community events aimed at encouraging a drug-free lifestyle are planned, community volunteers recognized, and community workshops conducted. The *confirmation/expansion* stage involves the same kinds of activities, occurring at a higher level of sophistication. External evaluation services obtain a more comprehensive community data base, activities that change local community policies and norms are initiated, media outreach provides information about local programs and reports local data trends, and the ongoing community focus groups and public forms maintain grassroots involvement. At the final stage, *professionalization,* activities consist of a very high level of data collection and analyses, of sophisticated media tracking of trends, of requests to local businesses to sponsor community-wide events, and of diversifying funding resources.

It is very important to pay close attention to the stage of readiness so that the type of the intervention is appropriate to the stage. For example, a community in the *denial* stage is not ready to conduct a focus group aimed at developing strategies for intervention. Likewise, a community at the *tolerance* level would not attend a drug-free community event. It is important at all stages to continue monitoring the level of community readiness. Often events occur that may force a community to fall back to a lower stage of readiness. This could occur as a result of changes in tribal or community administration, changes in population, policy changes, changes in law enforcement, or other changes. Yet, communities report that when this type of event occurs, they re-assess and adapt interventions and continue efforts until they reach the desired stage of readiness.

The purpose of this chapter was to present the Community Readiness Model, describe the development of the scales and their utility in the area of drug and alcohol prevention, and offer interventions that have been found anecdotally to be effective at the various stages. However, it was discovered that the Community Readiness Model has the capacity to be used in arenas other than drug and alcohol use prevention, given slight modification to the questions the Model poses to participants.

The Application of the Community Readiness for Prevention Model for Other Health and Social Issues

In March of 1995, the Center's Community Team was invited to speak at a meeting of two Western regional tribes and their leaders. The tribes had experienced a great deal of environmental distress due to radiation poisoning and uranium dust contamination. The communities had to deal with grief due to the loss of many tribal members to cancer and from the other health consequences resulting from exposure to deadly substances. Further, because of the environmental destruction, many of the tribes' traditional plant and animal medicines were gone. They wanted to bring the communities together to reduce further threat and implement preventative and early cancer-detection mechanisms. They had tried other strategies but were unable to get anything started. A foundation based in the Eastern United States had heard of the community readiness work conducted by the Community Team and requested that it make a presentation to the tribal leaders. Although the team was somewhat reluctant to introduce the Community Readiness Model into a topic area other than drug and alcohol prevention, because of its ties to the Native community the team decided to introduce the theory and work with the participants to adapt the model to the situation.

The tribal members had no difficulty adapting the Model to their needs. They were able to classify each community at a specific stage of readiness. They used that information to develop a

step-by-step action plan. The group decided to make personal home visits to educate people in the community in an effort to develop community support for the programs and move beyond the immobilization created by grief. Community members visited then became part of the group, began visiting others, and momentum grew quite quickly. Once the community moved to the next level of community readiness, small informal focus groups were held to determine what nature the intervention should assume, e.g., pot lucks, public forums, visits to churches and tribal gatherings, and so forth. The groups decided to take several different directions and divided up the tasks.

The group has now established mobile mammogram vans at the high school and at smaller clinics and has provided all members of the community with early detection materials and contacts for available resources. The group continues to call the Community Team from time to time; it reports that it is still moving ahead and, further, that when it does get stuck, it reassesses the situation using the Community Readiness Model to identify the obstacles, and then goes from there.

The Center recently received a grant from the Centers for Disease Control and Prevention (CDC) to adapt the Community Readiness Model to the prevention of intimate-partner violence in rural communities. Early findings indicate that the model is viable for this effort as well. The Community Readiness Model dimensions, factors, and interview questions were adapted to address the issue of intimate-partner violence in rural communities. Following the adaptation of the interview questions and scales, the focus groups attempted to obtain further knowledge about both formal and informal community resources, as well as about community, cultural, and regional factors that may have either positively or negatively affected tolerance, acknowledgment, reporting, intervention, and prevention of intimate-partner violence. The next stage, currently in progress, in the project is to conduct individual interviews with women from the communities to get more in-depth information regarding the communities' attitudes and practices regarding intimate-partner violence. The final stage will be to

develop and test culturally appropriate strategies to help rural communities to increase community readiness for the prevention of intimate-partner violence. These experiences suggest that the basic Community Readiness Model is easily adaptable to other situations.

Conclusions

Many of the communities our Center staff has worked with have maintained contact and allowed follow-up on activities since the introduction of community readiness theory and prevention planning based on the theory. Most communities have moved forward toward either receiving funding or modifying applications to continue to seek funding to implement their prevention plans and strategies. Some communities have chosen not to utilize funding, but rather to engage the community in volunteer action. For those communities that have not moved forward, the reasons are varied, but a consistent theme has been either political change within the tribes and villages or personnel changes. For some, a critical community crisis has occurred that has taken the focus away from drug use prevention issues.

Although the Community Readiness Model was developed specifically for alcohol and drug abuse prevention, it was created with a broader aim of assessing readiness for a gamut of problems. These range from health and nutrition issues (such as sexually transmitted diseases, heart disease, and diet), to environmental issues (such as water and air quality, and litter and recycling), social issues (such as poverty and homelessness, drug abuse, and violence), and personal problems (such as depression and suicide). The model can therefore be applied to many kinds of community-based prevention initiatives.

Finally, effective community prevention must be based on multiple systems and utilize community resources and strengths. It must be culturally relevant and geared toward the long term. Community readiness takes these factors into account, and there-

fore it increases the potential for programs to be cost-effective, and to be focused and directed toward the desired result.

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